Colorado Medical Board Policy

POLICY NUMBER:	**40-12**
Title:	Office-Based Surgery and Anesthesia
Date Issued:	11/08/01
Date(s) Revised:	07/01/10
Reference:	
Purpose:	See policy statement introduction.

POLICY: On November 8, 2001, the Colorado Medical Board ("Board") adopted the attached policy statement concerning office-based surgery and anesthesia.

Introduction

This policy provides guidance regarding the provision of surgical and anesthesia services in office settings. The Board identifies the roles and responsibilities of physicians providing, or overseeing by proper delegation, surgical and/or anesthesia services in office settings. This policy does not extend or limit the scope of any license. Further, this policy is to be used in concert with state and federal requirements governing the provision of office based surgery and anesthesia.

This policy does not apply to minor surgical procedures performed under topical or local infiltration blocks. This policy applies to any procedure involving general and/or regional anesthesia and/or the use of conscious sedation.

For purposes of this policy "office based surgery" is defined as surgery that is performed in a facility outside a hospital or ambulatory surgical center licensed by the Colorado Department of Public Health and the Environment.

Guidelines for Office Based Surgery and Anesthesia

1. Selection of Procedures and Patients

In general, it is the responsibility of the surgeon to determine that the office is an appropriate forum for the particular procedure(s) to be performed on the particular patient. Furthermore, it is the responsibility of the surgeon and, when involved, the qualified anesthesia provider to determine that the patient is an appropriate candidate for the anesthesia to be provided in the office setting. However, it is the opinion of the Colorado Board of Medical Examiners that under generally accepted standards of practice in Colorado, the following procedures should not be performed in the office:

a) Procedures that may result in blood loss of more than 4% of the estimated blood volume in a patient with a normal hemoglobin;

b) Procedures requiring major or prolonged intracranial, intrathoracic, or abdominal cavity entry (except for micro-laparoscopic procedures);

c) Joint replacement procedures;

d) Procedures directly involving major blood vessels; and

e) Emergent or life threatening procedures.

Additionally, liposuction procedures performed in the office setting:

1) Should not result in the removal of more than 5% of total body weight in supernatant fat or more than 4500 cc of supernatant fat, whichever is less;

2) Should not involve the use of more than 55mg/kg of Lidocaine for pure tumescent anesthesia;

3) Should, where epinephrine is utilized, use a concentration of epinephrine in tumescent solutions of 0.25 mg/L to 1.5 mg/L. The total dosage of epinephrine should be minimized, within these limits, and usually should not exceed 50 mcg/kg;

4) Should not result in the removal of more than 1500 cc of supernatant fat when combined with any other extensive surgical procedure; and

5) Should include appropriate monitoring of the patient as defined in paragraph 5(a)(2) of this policy statement.

The recommendations for limits on local anesthetic and supernatant fat are limits that may be safely observed by skilled physicians well trained in these techniques. Physicians without extensive training or experience in this area should not attempt to approach these limits.

2. Preoperative Evaluation

An appropriate preoperative evaluation, including history and physical, must be conducted prior to the performance of any surgery, regardless of setting. The surgeon must evaluate and discuss the risks and benefits of the surgical procedure with the patient and obtain informed consent from the patient. Additionally, the surgeon and qualified anesthesia provider must assess the patient before surgery to evaluate the risk of anesthesia.

3. Privileges

The surgeon should have staff privileges at a licensed hospital to perform the same procedure in that hospital as is being performed in the office setting. Alternatively, it is suggested that the surgeon be able to document satisfactory completion of training such as Board certification by a Board approved by the American Board of Medical Specialties or the American Osteopathic Association, or certify comparable background, training and experience.

A written transfer agreement with a licensed hospital within reasonable proximity should be obtained for emergency purposes. For the purposes of these guidelines, "reasonable proximity" is defined as less than thirty minutes transport time from office to hospital.

4. Records

The surgeon must maintain complete records of each surgical procedure; this would include anesthesia records when applicable. The records must contain documentation of informed consent from the patient. The record should document that the patient is medically stable before discharge. A discharge order should be written.

5. Anesthesia

a) Definitions:

1) For purposes of these guidelines, a "qualified anesthesia provider" is an appropriately trained and qualified physician, a certified registered nurse anesthetist ("CRNA"), or a physician assistant ("PA") appropriately trained and qualified in anesthesia working under the on-site supervision of a physician.

2) For the purposes of these guidelines, "monitoring a patient" includes ongoing evaluation of the patient's oxygenation, ventilation, circulation and temperature.

b) Administration of any general or regional anesthetic should be done by a qualified anesthesia provider. Administration of conscious sedation, when not done by a qualified anesthesia provider, should be directly supervised by a qualified physician.

c) A qualified anesthesia provider must be continuously present to monitor the patient when general or regional anesthesia is being used.

d) During any surgery where general or regional anesthesia or conscious sedation is given, qualified personnel in addition to the operating surgeon should be continuously present to monitor the patient.

e) All facilities should have a reliable source of electricity, oxygen, suction, resuscitative equipment and emergency drugs.

f) If services are being provided to infants or children, appropriately sized equipment, medication and resuscitative capabilities must be available.

g) When inhalation anesthesia is used, an anesthesia machine that is monitored and maintained in accordance with the standards of the American Society of Anesthesiologists should be used.

h) Explosive anesthetics should not be used.

i) Personnel with training in appropriate resuscitative techniques (ACLS or PALS) should be immediately available until all patients who have received anesthesia are discharged.

j) The patient should not be discharged home until the patient is medically stable.

k) At least 36 ampules of dantrolene must be immediately available for any procedures when general anesthesia and/or succinylcholine are administered.

6. Duration of Surgery

The planned duration of the surgical procedure(s) for each patient should be reasonable with respect to both the capabilities and training of the personnel available to monitor the patient and the nature of the facility.

It is not recommended that a patient stay overnight in an office setting following a surgical procedure unless that facility is appropriately accredited. "Accredited ambulatory surgical centers" are accredited as a Class B or Class C facility by one of the following organizations: Joint Commission on Accreditation of Healthcare Organizations (JCAHO); American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF); Accreditation Association for Ambulatory Health Care, Inc. (AAHC); or the Colorado Department of Public Health and the Environment.

7. Complications and Emergencies

   a) If a patient does not meet discharge criteria and is not in a Class B or Class C facility, the patient should be transferred to an appropriately accredited ambulatory care center or a licensed hospital within reasonable proximity.

   b) The facility should have written protocols for cardiopulmonary emergencies.

   c) The surgeon and at least one assistant should be currently certified in Basic Life Support. Additionally, if a qualified anesthesia provider is not managing the anesthesia, the surgeon and at least one assistant should be currently certified in Advanced Cardiac Life Support.

   d) All facility personnel should be appropriately trained in and regularly review the facility's written emergency protocols.

   e) The facility should have written protocols for external events that may affect office-based surgical procedures, such as fire, flood or tornadoes.

   f) Back-up power sufficient to ensure patient protection in the event of an emergency should be available.